

**Testimony by Barbara Spivak, M.D.  
before the Division of Health Care Finance and Policy,  
Executive Office of Health and Human Services  
The Commonwealth of Massachusetts  
Hearing on health care provider and payer costs and cost trends  
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Commissioner Morales, members of the Division of Health Care Finance and Policy and the Office of the Attorney General, Mr. Bailit, fellow panel members, fellow citizens, my name is Barbara Spivak, M.D. I am a practicing physician as well as president and chairman of the board of the Mount Auburn Cambridge Independent Practice Association (MACIPA). MACIPA is a physician organization in the Commonwealth that includes approximately 500 physicians who are affiliated with Mount Auburn Hospital and/or the Cambridge Health Alliance. I appreciate the opportunity to testify today about health care delivery systems and how MACIPA has been able to improve the quality of care provided by MACIPA physicians while controlling cost. I support the recommendation of the Payment Reform Commission to move more groups to a global payment methodology for physicians and hospitals. MACIPA has operated in a global payment framework for over 15 years. We have shown that it can be done and what it takes to do it.

Initially, MACIPA was formed in 1985, to organize physicians, to negotiate with HMOs and to begin to work together in the new managed care environment. Over time, we have added many services for our physician members as we took on more of the risk from the insurers. We now have four (4) major risk contracts, with Blue Cross and Blue Shield of

Massachusetts (BCBSMA), Tufts Health Plan, Tufts Health Plan Medicare Preferred and Harvard Pilgrim Health Care. MACIPA's contracting model is based on developing with each insurer a risk-adjusted budget that covers all or most of the care delivered to our patients. This contracting model is very similar to the model that is being recommended under the Accountable Care Organization model. We share the risk with our partner, Mount Auburn Hospital. At MACIPA, we emphasize innovation and lead our physicians in new ventures to improve health care quality and patient care. Our physicians practice medicine in many small offices, yet we try to function as an integrated delivery system with MACIPA providing centralized services that physicians are not able to provide themselves. Our infrastructure includes a staff of case managers (all of whom are registered nurses), data analysts, a clinical pharmacist, medical directors, and IT professionals who implement and support an electronic health record, managers and directors. Our staff offers a range of services- clinical, technical, analytical and managerial - all needed to support the physicians so that they can be successful in a global payment environment.

What we have created at Mount Auburn Hospital and MACIPA can be reproduced by other groups or organizations. Many hospitals and physician organizations have come to us over the past year to learn about how we operate, what our infrastructure is, the programs we provide, and how we are staffed. We believe that in order to support global payment models physician organizations will need to develop a centralized infrastructure which will need to be funded with significant financial investments by the Commonwealth and/or the health plans. The physician organizations will need to be led

by a strong physician leader making it very important that physician leadership development not be overlooked.

Capitation failed in the 1990's for many reasons. Global payments were too low and organizations did not have the infrastructure that was needed to succeed. Physicians and patients viewed capitation as a way to decrease costs by limiting care, not as a system that would improve the quality of care and support patients by providing more services and more preventive care. Providers and patients need to understand that delivering care within a network will improve quality, decrease duplication of tests and lower cost. Incentives to refer care to high quality, low cost facilities must be aligned for both providers and patients.

It will take time for the Commonwealth to move to a global payment system. We should begin by encouraging the formation of groups and physician organizations with the infrastructure and systems that support physicians, and by expecting that each patient will have a primary care physician, as in an HMO model. One such approach being piloted is the medical home model for certain diseases like diabetes. Another approach is with contracts such as the BCBSMA Alternative Quality Contract (AQC). The AQC is a global payment model with quality improvement incentives. Organizations participating in the AQC are learning what it takes to do well in this type of contract and are investing in the infrastructure needed to succeed. However, not all groups or physicians will be able to work within this model and more modest changes will be needed as well.

The elements that are necessary to make a global payment contract work are not easy to implement and take significant resources of time, money and personnel. The factors that have made MACIPA successful have taken years to build. We were fortunate to begin with a strong primary care physician base that has continued over the years. Our organizational structure is one that encourages education as the primary method of changing physician behavior. We have focused on improving care, for example, by prescribing the right medication and doing the right test the first time. Our pharmacy management program has enabled us to decrease our pharmacy costs significantly. We have managed pharmacy risk for 10 years. In the early years, physicians were slow to accept what we were doing but now they have high praise for the systems we have developed to interchange prescriptions, offer generic substitutes and increase the use of first line antibiotics. These have a direct impact on reducing cost and we have made it easy for the physicians to participate.

With regard to Care Management, we have established multiple roles for case managers for monitoring the health and well-being of patients who are admitted to the hospital or rehabilitation facilities. We are able to provide different levels of care based on severity of illness. By following patients through the continuum of services they receive, case managers get to know them on a personal level. Our case managers can ensure the patients receive the appropriate level of care and follow-up assistance even after returning home. Patients with chronic conditions are placed in more intensive case management programs with regular phone calls from the case manager to ensure that the patient is

taking all prescribed medications, following their physician's nutrition recommendations and complying with their recommended treatment.

Our Quality Improvement Department develops disease specific registries and cancer screening registries. We co-manage these lists of patients with our PCPs to improve patient compliance. As a bridge between PCPs, Specialists and the hospital, we are able to develop programs that will improve access, and educate patients and physicians about necessary care.

Another major undertaking at MACIPA is the implementation of electronic health records (EHR) for MACIPA physicians. There are currently 216 physicians and 722 users on the MACIPA EHR. MACIPA and Mount Auburn Hospital provide the funding and training for this new technology. We emphasize the importance of using electronic health records to improve patient care and health care quality. Going to a paperless system only improves quality if a provider uses it differently and sets up processes to improve care. Our goal is essentially to perform the functions of "population management" for our providers with the EHR as the basis of information.

Primary care physicians lead our organization. We believe that a strong primary care base is critical in combination with coordination of care with specialists. We bring primary care physicians together regularly in a "pod" structure - at monthly pod leader meetings and then in their individual pods. We work with our specialists to ensure that all of the health care that can be delivered within our network is provided by MACIPA

specialists. MACIPA specialists work with us to develop protocols and algorithms. We encourage specialists to work on quality and utilization improvement projects within their own specialty. Through our Board and committee structure, over 50 physicians are involved in developing policies for MACIPA. This reinforces our mission of leading providers to deliver the highest quality care at appropriate cost in a manner that maximizes physician and patient satisfaction. The global payment model with our four (4) major contracts has given us the flexibility to reward physicians financially for attending meetings and working on projects to improve the quality of care. Physicians work with our clinical and non-clinical staff, providing medical direction while the staff creates procedures, reports and systems. We return funds withheld from the physicians in the risk contracts and pay them a portion of the surplus we generate. Both the cost of these programs and the surpluses are shared by PCPs and Specialists.

An equally important element in our success is the relationship with our risk partner, Mount Auburn Hospital, and with the Cambridge Health Alliance. Both have a strong commitment to primary care, to developing quality improvement programs and to collaborating with physicians. Mount Auburn Hospital has been our partner in risk contracting for over 15 years. Our shared belief is that we need to be successful together, not at the other's expense. Our teamwork and our shared vision allowed us to be the first organization to negotiate the Alternative Quality Contract (AQC) with Blue Cross and Blue Shield of Massachusetts, a model that the Division and the Commonwealth should review as part of the payer costs and cost trends examination.

Thank you for the opportunity to testify on these important issues. I believe that global payments coupled with quality incentives are a better way to incent physicians to improve quality and control cost than standard fee for service payments. We have made it work at MACIPA for 15 years and I believe that other organizations can do it too.

I will be happy to answer questions.